

FILED OCT 30 1948

Registration District No.

318

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No.

State File No.

34248

9075

Registrar's No.

1. PLACE OF DEATH:

(a) County ST. Louis  
(b) City or town ST. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2720 Indiana Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME

Baby Hilker

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife NONE

6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
(Day) (Year)

7. Birth date of deceased OCT  
(Month)

17 1948  
(Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

2

hr.

min.

9. Birthplace

ST. Louis  
(City, town, or county)

MISSOURI  
(State or foreign country)

10. Usual occupation

NONE

11. Industry or business

NONE

12. Name

Walter B. Hilker

13. Birthplace

ST. Louis  
(City, town, or county)

MISSOURI  
(State or foreign country)

14. Maiden name

Ruth KING

15. Birthplace

ST. Louis  
(City, town, or county)

MISSOURI  
(State or foreign country)

16. (a) Informant

Ruth Hilker

(b) Address

2720 Indiana Ave.

17. (a)

BURIAL  
(Burial, cremation, or removal)

(b) Date thereof 10-20-48  
(Month) (Day) (Year)

(c) Place: burial or cremation

ST. Matthew's Cem.

18. (a) Signature of funeral director

With Bros. & Co.

(b) Address

2929

Jefferson Ave.

19. (a)

OCT 20 1948  
(Date received local registrar)

J. B. Foster  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ST. Louis  
(If outside city or town limits, write "RURAL")  
(c) City or town ST. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2720 Indiana Ave.  
(If rural, give location)  
(e) Citizen of foreign country? 23 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 19  
year 1948 hour 12 minute 9 A.M.

21. I hereby certify that I attended the deceased from Oct. 17, 1948 to Oct 19, 1948  
that I last saw her alive on Oct. 18, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death

Premature Birth

Duration

5 1/2  
mo.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury 7

23. Signature Dr. M. J. B. Foster (M. D. or other) 7-19

Address 3014 S. Jefferson Date signed Oct 19, 1948

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*Not Embalmed*

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Harold C. Witt*

Licensed Embalmer No. *4353*

P. O. Address. *2929 S. Jefferson*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**